SUPPLEMENTAL AGREEMENT NO. 3

Contract Number: **559**

Contract Title: **Self-funded Medical Program**

Contractor: **AvMed Inc. d/b/a AvMed Health Plan(s)**
9400 So. Dadeland Blvd, Ste. 409
Miami, FL 33156

In accordance with the above referenced Contract, this Supplemental Agreement, when properly executed, shall:

A. Amend the Scope of Services (Appendix A), Sections 2.3 (General Information), 2.6 (Data Provisions), and 2.7 (Administration Provisions) with the underlined language as follows:

For purposes of this Agreement, the term Domestic Partner shall be defined as set forth in Ordinance 11A-71 of the Code of Miami-Dade County and are registered according to that Section.

2.3.4 The County contributes 97% of the single employee cost for the POS plan and 100% of the single employee cost of the HMO plan options. Employees contribute the difference between the cost for single coverage and the County contribution. Employees also contribute the full cost for dependent coverage. The Employees' contributions to the cost are offered on a pre-tax basis with the exception of contributions for Domestic Partner, eligible dependents of Domestic Partner or children between ages 25 (after end of calendar year in which they turn 25) and 30 (to end of calendar year) which are on a post-tax basis. Retirees contribute 100% of the cost of their coverage. The County reserves the right to change its contribution strategy at any time. The Contractor's ASO fees and Stop Loss Premiums shall remain valid regardless of the contribution strategy.

2.3.6 Any full-time County employee who has completed 90 days of employment is eligible. Any part-time employee who consistently works at least 60 hours bi-weekly and has completed 90 continuous days of employment is eligible. Executives, as identified by the County, are eligible for coverage on their first day of employment. If an election is made, coverage is effective the first day of the month following or coincident to the completion of the 90 day eligibility period without any actively-at-work exclusion. Employees are offered a 30 day grace period to enroll beyond their initial eligibility date. Coverage requested during the grace period becomes effective the first of the following month.

Dependent eligibility is defined as follows:

(a) Spouse or Domestic Partner (unless an eligible County employee).

(b) Unmarried natural child, stepchild, foster child, child of a Domestic Partner, adopted child (including a child who is required to be eligible for membership as an adopted child in conformity to applicable law) or a child for whom the employee has been appointed a legal guardian, pursuant to a valid court order and the child is under the

limiting age. The eligibility limiting age for an unmarried child is the end of the calendar year in which the child reaches age 19. Coverage may be extended to the end of the calendar year in which the child reaches age 25, if all of the following requirements are met: (1) the unmarried child is dependent upon the employee for support, and (2) the unmarried child is living in the employee's household or the unmarried child is a full or part-time student. The plan shall require acceptable documentation that the child meets and continues to meet such requirements.

(c) Coverage for an unmarried dependent child may be continued beyond age 25 if the child is mentally or physically disabled. Proof of disability may be required.

(d) Unmarried dependent children and dependent children of Domestic Partner from age 25 to age 30 (end of calendar year) are eligible for coverage as stipulated by Florida Statue FSS 627.6562.

2.3.13 The following rules apply for adding/deleting dependents:

(a) New Dependents - A dependent may be added to the medical plan by submitting an application within 45 days (60 days for newborns) of acquiring the dependent. The employee must enroll the dependent within 45 days (60 days for newborns) after the marriage, registration of Domestic Partnership or birth/adoption of a child. Coverage for a new spouse or Domestic Partner is effective the first day of the month following receipt of the application. Coverage for a newborn, child placed for adoption, or adopted is effective as of the date of birth or earlier of (i) placement for adoption, or (ii) adoption date. The change in premium, if applicable, is effective the first day of the month following the birth or the earlier of (i) placement for adoption or (ii) adoption date.

(b) If eligible employees have declined coverage for themselves or their dependents because of other insurance coverage and the other coverage ends, they may request enrollment within 45 days after the other ends.

(c) Change of Family Status – A dependent may be added or deleted to the Group Medical Plan program at anytime during the year under HIPAA or IRS Section 125 provisions. Proof of the change in family status must be submitted within 45 days. Changes to add a new dependent become effective the first day of the month following receipt of a timely request with the exception of birth, adoption or placement for adoption which become effective as of birth or the *earlier* of: a) adoption or b) placement for adoption. Payroll changes to add a newborn are processed in accordance with Florida Statute 641.31(9). If the Change in Status (CIS) Form is received by Benefits Administration Unit (BAU) within the first 31 days from birth, the premium is waived for the first 31 days. If the CIS Form is received after the first 31 days, but within 60 days of the event, the new premium will be charged retroactive to the date of birth. The same applies when adding an adopted child or child placed for adoption. The premium is waived if the CIS Form is received by BAU within the first 31 days from the *earlier* of: a) adoption or b) placement for adoption. If the CIS Form is received after the first 31 days, but within 60 days of the event, the new premium will be charged retroactive to the *earlier* of: a) adoption or b) placement for adoption. Payroll changes to delete a dependent for other than those events specified in this paragraph, become effective the first day of the pay period following receipt by the BAU.

2.6.1 The Contractor shall provide the following reports electronically to the Director of Risk Management, with a copy to the County's Benefits Manager, Jackson Health System and the County's consultant (which shall include the information as stated below):

(a) **Monthly Paid Claims Activity Reports** - shall be segregated by active employees, Medicare and Non-Medicare eligible retirees, and further categorized with dependents and COBRA beneficiaries identified separately (active and retirees). The Monthly Financial Performance Report includes tracking of the Contractor Claims Guarantee for CY 2008; monthly enrollment, fees and claims experience; network costs; individual claims in excess of $250,000; members with aggregate claims expenses in excess of $250,000; and Claim Lag Reporting.

(b) **Annual Utilization Data Reports** - showing inpatient utilization by hospital, outpatient utilization and physician by type of service. The Annual Group Profile includes Membership, Cost and Utilization Metrics – Medical and Pharmacy, Network Cost and Utilization, Diagnosis Overview, Care/Disease Management Reports, and Prescription Drug Management Reports.

(c) **Annual Care Management/Disease Management Reports** — showing utilization by program.

(d) **Annual Prescription Drug Management Reports** - separately detailing name brand and generic drug usage. These reports shall include formulary use and approved non-formulary prescriptions.

(e) **Quarterly Employer Specific Pharmacy Rebate Tracking Report**

2.7.7 The Contractor shall administer appropriate procedures to monitor the status of over-age dependent children (19 and over) to ensure that satisfactory proof of eligibility is obtained and that coverage complies with Federal and State regulations, including COBRA. Procedures will address overage dependents in a timely manner to ensure that retroactive premiums adjustments are minimized. This includes coverage eligibility for Domestic Partner and dependent children of Domestic Partner.

2.7.8 The Contractor shall be responsible for providing all COBRA administration, including mailing of initial COBRA notification after receiving notification of a qualifying event from the County. The services required also include billing of beneficiaries and collection of appropriate premiums. The Contractor shall offer a COBRA-like continuation of coverage for Domestic Partner or dependents of Domestic Partner who experience qualifying events. The County or Jackson Health System shall submit any request to revise administrative responsibilities under COBRA, in writing, at least 60 days prior to the intended effective date.

B. Delete the provisions listed in Section 2.8.5 in its entirety. The requirements for the provision of claims data is appropriately outlined in Section 2.6.1 as modified above.

All terms, covenants and conditions of the original Contract and Supplemental Agreements thereto shall remain in full force and effect, except to the extent herein amended.

IN WITNESS WHEREOF, the parties have executed this Supplemental Agreement to County Contract No. 559 effective as of the date herein above set forth.

Contractor

By: _____

Name: Frank Jantzen III

Title: V.P. Client Service

Date: March 17, 2009

Attest: _____
Corporate Secretary

Corporate Seal

MARIANNE A. DIVITA
MY COMMISSION # DD 776156
EXPIRES: April 7, 2012
Bonded Thru Notary Public Underwriters

3/17/09

Miami-Dade County

By: Rita Silva

Name: Rita Silva p.m.s.

Title: Sr. Procurement Contracting Officer

Date: 3/20/09

Attest: _____ Clerk of the Board 3/23/09

COUNTY COMMISSIONERS COUNTY FLORIDA

Approved as to form
and legal sufficiency

_____
Assistant County Attorney